MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11931

CERTIFICATE OF DEATH

11940
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Grantsville, Md.
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/Rural Grantsville, Md.
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First THOMAS — Middle T. — Last BITTINGER

4. DATE OF DEATH: Month November — Day 18 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: April, 16, 1887

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR — Months: — Days:
IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY: own farm

11. BIRTHPLACE (State or foreign country): Garrett Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elijah Bittinger

14. MOTHER'S MAIDEN NAME: Eliza Hare

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-36-9761

17. INFORMANT — Address: Mrs. Margaret Durst, Grantsville, Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Terminal.
331X
DUE TO (b): Arteriosclerosis, Generalized
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Genito-urinary and Gastro-intestinal Hemorrhage

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 11, 1957, to Nov 18, 1957, that I last saw the deceased alive on Nov 15, 1957, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ruth Peachey M.D. — ADDRESS (Street, city or town, state): Grantsville, Md. — DATE SIGNED: 11/29/57

PHYSICIAN'S NAME (Type): Ruth Peachey M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/21/57

22c. NAME OF CEMETERY OR CREMATORY: Grantsville

22d. LOCATION (City, town, or county) (State): Grantsville, Garrett Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Clint J. Newman — ADDRESS: Grantsville, Md.

24a. REC'D BY REGISTRAR — DATE: NOV 25 '57

24b. REGISTRAR'S SIGNATURE: A. Wisecarver

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11932

11941

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH
a. COUNTY Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gormania, W. Va.
c. LENGTH OF STAY IN 1b 75 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 Mi. West Gormania,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Rural Gormania, W. Va.
d. STREET ADDRESS 6 Mi. West Gormania
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First Brown Middle Milison Last Cooper
4. DATE OF DEATH Month November Day 7, Year 1957
5. SEX Male
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Nov. 5, 1882
9. AGE (In years last birthday) 75 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Own Farm
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME David Cooper
14. MOTHER'S MAIDEN NAME Emma Lee
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ---
17. INFORMANT Mrs. Brown Coo per Address R. D. Gormania, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cerebral hemorrage with rt
443X
DUE TO (b) Old paralysis — 3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypertension Heart Disease — 5 yrs.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1955, to Nov. 7, 1957, that I last saw the deceased alive on Nov. 6, 1957, and that death occurred at 6:10P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE Ralph Calandrella M.D. ADDRESS (Street, city or town, state) Kitzmiller, Md DATE SIGNED Nov. 9 57

PHYSICIAN'S NAME (Type) Ralph Calandrella, M. D. Kitzmiller, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11/10/1957
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery
22d. LOCATION (City, town, or county) near Gormania, W. Va. (State)

23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton ADDRESS Oakland, Md.
24a. REC'D BY REGISTRAR DATE 11/10/1957
24b. REGISTRAR'S SIGNATURE Julia L. Rowan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11933 **CERTIFICATE OF DEATH** 11942

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY GARRETT MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE MD
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE, MD x2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First LEONARD Middle JONAS Last CUSTER

4. DATE OF DEATH Month NOV. Day 7 Year 1957

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH SEPT. 22, 1902

9. AGE (In years last birthday) 55 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICK LAYER

10b. KIND OF BUSINESS OR INDUSTRY HOME BUILDING

11. BIRTHPLACE (State or foreign country) GRANTSVILLE, MD

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME JOHN M CUSTER

14. MOTHER'S MAIDEN NAME MARY BEACHY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 192-03-9922

17. INFORMANT Address Mrs Mable Bender, Grantsville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 15 min.

420.0

DUE TO (b) Arteriosclerotic heart disease — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic pulmonary fibrosis, bilateral

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1956, to Nov. 7, 1957, that I last saw the deceased alive on Nov. 5, 1957, and that death occurred at 9:00 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE A Paige Strong M.D. ADDRESS (Street, city or town, state) Salisbury, Penna DATE SIGNED Nov. 7, 1957

PHYSICIAN'S NAME (Type) A. PAIGE STRONG MD SALISBURY PA.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 11-10-57

22c. NAME OF CEMETERY OR CREMATORY Casselman Menonite Cem.

22d. LOCATION (City, town, or county) (State) Grantsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Donald F. Newman Grantsville, Maryland

24a. REC'D BY REGISTRAR DATE NOV 13 57

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 3 should be detached and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

: 11934 11943

Reg. Dist. No. 166

1. PLACE OF DEATH
a. COUNTY Garrett MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Oakland
c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON GROVE MD
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
d. STREET ADDRESS 15X0.2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First CHARLES Middle KIRKWOOD Last DAVIES JR.
4. DATE OF DEATH Month NOVEMBER Day 9 Year 1957
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH JUNE 5 1908
9. AGE (In years last birthday) 49 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME CHARLES DAVIES
14. MOTHER'S MAIDEN NAME EDITH SIMMONS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.
16. SOCIAL SECURITY NO. 575-38-0971
17. INFORMANT MRS. CHARLES DAVIES Address WASHINGTON GROVE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 20 min
DUE TO (b)
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
260X Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE A. Baumgartner M.D.
EXAMINER'S NAME (Type) A. BAUMGARTNER M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 11/9/57

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF NOV.-12-1957
22c. NAME OF CEMETERY OR CREMATORY DARNESTOWN CEMETERY
22d. LOCATION (City, town, or county) (State) NEAR GAITHERSBURG MD

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Emroy Bolden OAKLAND MD
24a. REC'D BY REGISTRAR DATE 11/9/57
24b. REGISTRAR'S SIGNATURE Julia A. Rowan R.R.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

.11935

11944/66 Reg. Dist. No.

1

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Garrett — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland c. LENGTH OF STAY IN 1b: 14 ds.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westernport 01X2.2
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Weeks Nursing Home	d. STREET ADDRESS: r.D. 1 e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Gurnie	Middle: Lee	Last: Durst.	4. DATE OF DEATH	Month: Nov.	Day: 21	Year: 1957	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: April 19, 1886	9. AGE (In years last birthday): 71 yrs.	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer	10b. KIND OF BUSINESS OR INDUSTRY: Farm	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: William F. Durst		14. MOTHER'S MAIDEN NAME: Mary A. Barncord	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 0	17. INFORMANT: Mrs. Burrell Poland- Address: Luke, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): STARVATION — INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS

442x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): ARTERIOSCLEROTIC CARDIO-RENAL

DUE TO (c): D. SENSE — YRS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): TNJT. PIE DECUBITUS ULCERS OLD STROKE — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from NOV. 8, 1957, to NOV 21st, 1957, that I last saw the deceased alive on NOV 20th, 1957, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James H. Fenton, Jr. M.D. — ADDRESS (Street, city or town, state): 58 2nd St. Oakland, Md. — DATE SIGNED: 11-23-57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 11/25/57	22c. NAME OF CEMETERY OR CREMATORY: Philos Cem.	22d. LOCATION (City, town, or county): Westernport	(State): Md.	
23. FUNERAL DIRECTOR'S SIGNATURE: E. J. Beal	ADDRESS: Westernport, Md.	24a. REC'D BY REGISTRAR DATE: NOV 26 19	24b. REGISTRAR'S SIGNATURE: Julia Rowen		

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11936

CERTIFICATE OF DEATH

11945 6 6

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Deer Park
c. LENGTH OF STAY IN 1b: 93 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5 Mi. So. Deer Park

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Deer Park,
d. STREET ADDRESS: 5 Mi. So. Deer Park
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Susann — Middle: Elvinaa — Last: Harvey

4. DATE OF DEATH: Month: November — Day: 17, — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: July 22, 1864

9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Garrett Moon

14. MOTHER'S MAIDEN NAME: Ja ne Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: -----

17. INFORMANT: Paul Harvey — Address: R D Deer Park , Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks
420.0
DUE TO
(b): Arteriosclerotic Heart Disease — 20 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1957, to Nov. 17, 1957, that I last saw the deceased alive on November 15, 1957, and that death occurred at 10:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Herbert H. Leighton M.D. — ADDRESS (Street, city or town, state): 77 Oak St. Oakland, Md. — DATE SIGNED: Nov. 18, 57

PHYSICIAN'S NAME (Type): Herbert H. Leigh ton M.D. — Oakland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/19/1957

22c. NAME OF CEMETERY OR CREMATORY: N.B. Harvey Family Cemetery

22d. LOCATION (City, town, or county) (State): 5 Mi. So. Mt. La ke Pa rk, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. C. Leighton — ADDRESS: Oakland, Md.

24a. REC'D BY REGISTRAR DATE: 11/18/57

24b. REGISTRAR'S SIGNATURE: Julia G. Howard R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11937 CERTIFICATE OF DEATH

Reg. Dist. No. 11946

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: CUPPETT NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO 21x0.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MAUD — Middle A. — Lost HOUCK
4. DATE OF DEATH: Month NOV. — Day 3 — Year 1957

5. SEX: FEMALE
6. COLOR OR RACE: WHITE.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN. 23, 1877
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): CUMBERLAND MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DAVID HOUCK
14. MOTHER'S MAIDEN NAME: MARY ANTHONY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: WM. O. HOUCK — Address: KINGWOOD W.VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart failure, — INTERVAL BETWEEN ONSET AND DEATH
422.1
DUE TO (b): Arterio sclerotic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Cardio-vascular disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/12/57, 19____, to 11/3/57, 19____, that I last saw the deceased alive on 10/13/57, 19____, and that death occurred at 11:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. L. Baumgartner M.D. ADDRESS (Street, city or town, state): 25 ALDER ST DATE SIGNED: 11/4/57
PHYSICIAN'S NAME (Type): E. L. BAUMGARTNER. OAKLAND MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11/6/57
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY
22d. LOCATION (City, town, or county) (State): CUMBERLAND MD

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc. ADDRESS: CUMBERLAND MD
24a. REC'D BY REGISTRAR DATE: 11/6/57
24b. REGISTRAR'S SIGNATURE: Julia M Rowan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

RECEIVED

NOV 12 1957

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

, 11938 CERTIFICATE OF DEATH

Reg. Dist. No. 1/1947

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO OAKLAND
d. STREET ADDRESS: 176 4TH STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HELEN — Middle KING — Last HUGHES

4. DATE OF DEATH: Month NOVEMBER — Day 19 — Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JAN. 12, 1885

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: MILES KING

14. MOTHER'S MAIDEN NAME: MARTHA CORLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: JOSEPHINE KING — Address: OAKLAND MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Coronary Heart Disease — 2 years
DUE TO (c): Diabetes Mellitus — 20 years
260X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 15, 19 57 to November 19, 19 57, that I last saw the deceased alive on 19 Nov, 19 57, and that death occurred at 3:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. E. Pearce M.D. — ADDRESS (Street, city or town, state): Oakland Md — DATE SIGNED: 20 Nov 57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: NOV. 22 1957

22c. NAME OF CEMETERY OR CREMATORY: OAKLAND CEMETERY

22d. LOCATION (City, town, or county) (State): OAKLAND MD

23. FUNERAL DIRECTOR'S SIGNATURE: Elroy Boldin — ADDRESS: OAKLAND MD

24a. REC'D BY REGISTRAR DATE: 11/22/57

24b. REGISTRAR'S SIGNATURE: Julia A Rowan LR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/5S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11939 **CERTIFICATE OF DEATH** 11948

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Accident, Md.
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Accident, Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PETER Middle JAMES Last KAHL

4. DATE OF DEATH: Month November Day 22 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 30, 1871

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter-retired

10b. KIND OF BUSINESS OR INDUSTRY: self-employed

11. BIRTHPLACE (State or foreign country): Accident, Garrett Co.,

12. CITIZEN OF WHAT COUNTRY? Md. U.S.A.

13. FATHER'S NAME: Valentine Kahl

14. MOTHER'S MAIDEN NAME: Emma Hardin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Ada Kahl, Address: Accident, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate
420.1
DUE TO (b): Arteriosclerotic Cardio-Renal — 4 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 6-8-57, 19____, to 10-5, 1957, that I last saw the deceased alive on 10-5, 1957, and that death occurred at 3 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James H. Feaster Jr. M.D. ADDRESS (Street, city or town, state): 58 2nd St. Oakland, Md DATE SIGNED: 11-25-57

PHYSICIAN'S NAME (Type): James H. Feaster Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/25/57

22c. NAME OF CEMETERY OR CREMATORY: English Lutheran

22d. LOCATION (City, town, or county) (State): Accident, Garrett Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Don J. Newman ADDRESS: Grantsville, Md.

24a. REC'D BY REGISTRAR DATE: NOV 29 '57

24b. REGISTRAR'S SIGNATURE: W. H. Leach

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11940

CERTIFICATE OF DEATH

11949

Reg. Dist. No. 163

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westernport
c. LENGTH OF STAY IN 1b: 3 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4 Mi W. Westernport

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport -rural
d. STREET ADDRESS: ½ Mi. W. Westernport
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Benjamin — Middle: Wall — Last: Kalbaugh

4. DATE OF DEATH: Month: Nov — Day: 2 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 23, 1877

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shop foreman

10b. KIND OF BUSINESS OR INDUSTRY: Railroad shops

11. BIRTHPLACE (State or foreign country): Westernport, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jack Kalbaugh

14. MOTHER'S MAIDEN NAME: Sarah Simmons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-12-4703

17. INFORMANT: Harry Kalbaugh—Westernport, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 Minutes
DUE TO
331X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b) Arteno-sclerosis and Hypertension — 5 Years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Prostatic Hypertrophy

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour / Month, Day, Year — [redacted] a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 10, 1952, to Nov. 2, 1957, that I last saw the deceased alive on Oct. 28, 1957, and that death occurred at 1140 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul R. Wilson M.D. — ADDRESS (Street, city or town, state): Piedmont, W. Va. — DATE SIGNED: Nov. 4, 1957

PHYSICIAN'S NAME (Type): Paul R. Wilson, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 5, 57
22c. NAME OF CEMETERY OR CREMATORY: Philos Cem.
22d. LOCATION (City, town, or county): Westernport, (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E. J. Boal
ADDRESS: Westernport, Md.
24a. REC'D BY REGISTRAR DATE: 11-5-57
24b. REGISTRAR'S SIGNATURE: Dorsey Patterson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11941 **CERTIFICATE OF DEATH**

11950

Reg. Dist. No. 166

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b: 60 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Weeks Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Oakland
d. STREET ADDRESS: Dennett Road
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Elizab eth — Middle: Hannah — Last: Kloepfel

4. DATE OF DEATH: November 14, 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 20, 1877

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Miller

14. MOTHER'S MAIDEN NAME: Mary Slabau gh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ----

17. INFORMANT: Helen Lough — Address: Mt. Lake Pa rk, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): STARVATION — INTERVAL BETWEEN ONSET AND DEATH: 10 days
571.1
DUE TO (b): DIARRHEA, C.U — 1 week
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): SENILITY

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN, 1957, to NOV. 14, 1957, that I last saw the deceased alive on NOV. 13th, 1957, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James H Feaster Jr. M.D. — ADDRESS (Street, city or town, state): 58 2nd St. Oakland, Md. — DATE SIGNED: 11-16-57

PHYSICIAN'S NAME (Type): James H., Feaster, Jr. M.D. — Oakland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/16/1957

22c. NAME OF CEMETERY OR CREMATORY: Gnegy Church Cemetery

22d. LOCATION (City, town, or county) (State): 11 Mi. So. Oakland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. C. Leighton — ADDRESS: Oakland, Md.

24a. REC'D BY REGISTRAR DATE: 11/16/57

24b. REGISTRAR'S SIGNATURE: Julia L. Fowler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11942 **CERTIFICATE OF DEATH** Reg. Dist. No. 11951

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL ROUTE 1, OAKLAND x2
d. STREET ADDRESS: BOX 135
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH Middle Lost LEE

4. DATE OF DEATH: Month NOVEMBER Day 9, Year 1957

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: OCTOBER 5, 1880
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: GENERAL
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: DAVID LEE
14. MOTHER'S MAIDEN NAME: ELIZA LEE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: JOSEPH LEE (SELF), BOX 135, R. 1, OAKLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	PNEUMONIA LOBAR, C.J.	6 days
490X Conditions, if ony, which gave rise to immediate couse (a), stating the underlying cause last. DUE TO (b)	ARTERIOSCLEROTIC CARDIO-RENAL	yrs.
DUE TO (c)	DISEASE	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from DEC, 1948, to 11-8, 1957, that I last saw the deceased alive on NOVEMBER 8TH, 1957, and that death occurred at 11:05 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James H. Feaster, Jr. M.D. ADDRESS (Street, city or town, state): OAKLAND, MD. DATE SIGNED: 11/9/57

PHYSICIAN'S NAME (Type): JAMES H. FEASTER, JR, M.D. OAKLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: NOV-11-1957
22c. NAME OF CEMETERY OR CREMATORY: OAK GROVE CEMETERY
22d. LOCATION (City, town, or county) (State): NEAR GORMAN MD

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Emroy Bolden OAKLAND MD
24a. REG'D BY REGISTRAR DATE: 11/10/57
24b. REGISTRAR'S SIGNATURE: Julia A. Rowan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11943 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11952 Reg. Dist. No. 106

1. **PLACE OF DEATH**
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL GORMANIA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address):

2. **USUAL RESIDENCE** (Where deceased lived. If Institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: GARRETT.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL GORMANIA. XI
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. **NAME OF DECEASED** (Type or print): First MARSHALL Middle TALMAGE Last LEWIS

4. **DATE OF DEATH**: Month NOV. Day 18 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV.-19, 1898

9. AGE (In years last birthday): 59 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): GARRETT MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EMORY LEWIS

14. MOTHER'S MAIDEN NAME: STELLA KING.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 232-09-5396

17. **INFORMANT** Address: MRS. BIRTHA LEWIS GORMANIA W. VA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion (Left) — INTERVAL BETWEEN ONSET AND DEATH

420.1

DUE TO (b): Arteriosclerosis

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Congestion & Edema

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. L. Baumgartner M.D.

EXAMINER'S NAME (Type): E. L. BAUMGARTNER MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 11/18/57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: NOV-21-1957

22c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW

22d. LOCATION (City, town, or county) (State): FAIRVIEW MD

23. FUNERAL DIRECTOR'S SIGNATURE: Wayne C. Spigle ADDRESS: DAVIS W. VA

24a. REC'D BY REGISTRAR DATE: 11/21/57

24b. REGISTRAR'S SIGNATURE: Edward Ronson LR

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11944 11953

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland,
c. LENGTH OF STAY IN 1b: 80 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Alder St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Oakland
d. STREET ADDRESS: Alder St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Asa; Middle: Totten; Last: Matthews

4. DATE OF DEATH: Month: November; Day: 2; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 13, 1875

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer

10b. KIND OF BUSINESS OR INDUSTRY: Private Practice

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Simon Matthews

14. MOTHER'S MAIDEN NAME: Elizabeth Totten

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-32-3239

17. INFORMANT: Mrs. Frances Matthews — Address: Oakland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema, Acute — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO
151X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carcinoma of the Lung, Metastatic — unknown
DUE TO
(c) Carcinoma of Stomach, Infiltrating — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1957, to Nov. 2, 1957, that I last saw the deceased alive on Nov. 2, 1957, and that death occurred at 2:30P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Herbert H. Leighton M.D. — ADDRESS (Street, city or town, state): 77 Oak St, Oakland, Md. — DATE SIGNED: Nov. 4, 1957

PHYSICIAN'S NAME (Type): Herbert H. Leighton, M.D. — Oakland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/5/1957
22c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery
22d. LOCATION (City, town, or county) (State): Oakland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. C. Leighton — ADDRESS: Oakland, Md.

24a. REC'D BY REGISTRAR DATE: 11/4/57
24b. REGISTRAR'S SIGNATURE: Julia A. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11945

CERTIFICATE OF DEATH

Reg. Dist. No. 11954

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Cuppett Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY: Grant
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bayard 85 x 3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LAURA; Middle BLANCHE; Last MAY

4. DATE OF DEATH: Month NOVEMBER; Day 22; Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV. 10, 1867

9. AGE (In years last birthday): 90 yrs.

IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE KEEPER

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): OHIO

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOSIAH MAY

14. MOTHER'S MAIDEN NAME: HANNAH STOUFFER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: ARTHUR S. MAY — Address: BAYARD, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 day
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Cardio Vascular Disease — 15 yrs.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 10, 1957 to Nov. 22, 1957 that I last saw the deceased alive on Nov. 19, 1957, and that death occurred at 12:45P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Herbert H. Leighton M.D. — ADDRESS (Street, city or town, state): 77 Oak St. Oakland Md. — DATE SIGNED: 11/25/57

PHYSICIAN'S NAME (Type): Herbert H. Leighton, M. D. Oakland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/25/1957

22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY

22d. LOCATION (City, town, or county) (State): CUMBERLAND, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Otho F. Sharpless — ADDRESS: BLAINE, W.Va.

24a. REC'D BY REGISTRAR DATE: 11/23/57

24b. REGISTRAR'S SIGNATURE: Judia C. Howard R.R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11946 **CERTIFICATE OF DEATH** Reg. Dist. No. 11955

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b: ONE WEEK
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA — b. COUNTY: PRESTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): AURORA 85 X-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALLETTA — Middle — Last MAYER

4. DATE OF DEATH: Month NOVEMBER — Day 30, — Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: APRIL 25, 1873

9. AGE (In years last birthday): 84 84 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House keeper
10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALLEN FORMAN

14. MOTHER'S MAIDEN NAME: ~~UNKNOWN~~ Caroline Forquer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: LEWIS R. JONES, FIRST NAT'L BANK BLD'G, OAKLAND MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 3 WEEKS
DUE TO (b): Arterio Sclerotic Cardio-Renal disease — YEARS
DUE TO (c): Obesity — YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 19 57, to Nov 29 19 57, that I last saw the deceased alive on Nov 29 19 57, and that death occurred at 5:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John W. Feaster Jr. M.D. — ADDRESS (Street, city or town, state): 58 2nd St. Oakland Md. — DATE SIGNED: 11-30-57

PHYSICIAN'S NAME (Type): JAMES H. FEASTER, M.D. OAKLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/3/1957
22c. NAME OF CEMETERY OR CREMATORY: Terra Alta Cemetery
22d. LOCATION (City, town, or county) (State): Terra Alta, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: H. C. Leighton — ADDRESS: Oakland, Md.

24a. RECD BY REGISTRAR DATE: 12/2/57 — 24b. REGISTRAR'S SIGNATURE: Julia A Rowan LR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11947 Item 9 Film G223 12-12-57 et

CERTIFICATE OF DEATH

11956 Reg. Dist. No. 766

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garrett County Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY: Preston
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Terra Alta
d. STREET ADDRESS: Route No. 1, Lime Plant Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Thaddeus; Middle Ellsworth; Last Meese

4. DATE OF DEATH: November 11, 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Aug. 27, 1886

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months 11; Days 14
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: General Farming

11. BIRTHPLACE (State or foreign country): McHenry, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Joseph B. Meese

14. MOTHER'S MAIDEN NAME: Mary Welsh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: H. Wade Meese, Oakland, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 5 min.
DUE TO: Myocardial Infarction — 16 days
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Coronary Artery Insufficiency — 2 years
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis and Senility

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 4, 1955, to Nov. 11, 1957, that I last saw the deceased alive on Nov. 11, 1957, and that death occurred at 4:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas E. Smith M.D.
ADDRESS (Street, city or town, state): Terra Alta, W.Va.
DATE SIGNED: November 12, 1957

PHYSICIAN'S NAME (Type): CHARLES E. SMITH

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 14, 1957
22c. NAME OF CEMETERY OR CREMATORY: Thayersville Cemetery
22d. LOCATION (City, town, or county) (State): Thayersville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: P.R.Watson
ADDRESS: Terra Alta, W.Va.
24a. REC'D BY REGISTRAR DATE: 11/14/57
24b. REGISTRAR'S SIGNATURE: Julia C. Rogers R

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11948 Item 8 FilmC223 12-16-57 et

CERTIFICATE OF DEATH

11957

Reg. Dist. No. 166

1. PLACE OF DEATH
a. COUNTY: GARRETT Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SWANTON Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: GARRETT.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 SWANTON MD.
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle EARL Last RECKNER

4. DATE OF DEATH: Month NOV. Day 27 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN.-19-1893

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: MERCHANT.

11. BIRTHPLACE (State or foreign country): BITTINGER MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: AMOS RECKNER

14. MOTHER'S MAIDEN NAME: ANNA BUCKEL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WORLD WAR #1

16. SOCIAL SECURITY NO.: 213-05-2731

17. INFORMANT: MRS. FREDA L. RECKNER Address: SWANTON MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 years
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Myocardial Heart Disease & Chronic Cardiac Hypertrophy — 4 years
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/18/ 19 55 to 11/27/ 19 57, that I last saw the deceased alive on 26 Nov 19 57, and that death occurred at 1:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A E Mance M.D. ADDRESS (Street, city or town, state): Oakland Md DATE SIGNED: 27 Nov 57

PHYSICIAN'S NAME (Type): A.E.MANCE, M.D., 101 THIRD ST., OAKLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: NOV.-29-1957

22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY

22d. LOCATION (City, town, or county) (State): NEAR SWANTON MD

23. FUNERAL DIRECTOR'S SIGNATURE: Emroy Bolden ADDRESS: OAKLAND MD.

24a. REC'D BY REGISTRAR DATE: 11/29/57

24b. REGISTRAR'S SIGNATURE: Julia A Brown LR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11949

CERTIFICATE OF DEATH

11958

Reg. Dist. No. 72

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Garrett

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland, Ma.

c. LENGTH OF STAY IN 1b: 25 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Accident, Md. x2

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Weeks Nursing Home, Oakland, Md.

d. STREET ADDRESS: 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA Middle KAHL Last RICHTER

4. DATE OF DEATH: Month November Day 3 Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 1, 1880

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Accident, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ludwig Kahl

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Walter Richter, Accident, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 10 mins.

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease — 4 yrs

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 2 Fractured Left Hip Sept. 24th 1957 (1043)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-29, 1957, to 10-29, 1957, that I last saw the deceased alive on 10-29, 1957, and that death occurred at 8:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James H. Foster, Jr. M.D. — ADDRESS (Street, city or town, state): 58 2nd St Oakland Md. — DATE SIGNED: 11-6-57

PHYSICIAN'S NAME (Type): J. H. Foster Jr. M.D. — 58 2nd St. Oakland Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/6/57

22c. NAME OF CEMETERY OR CREMATORY: Zion Lutheran

22d. LOCATION (City, town, or county) (State): Accident, Garrett Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Donald Newman — ADDRESS: Grantsville, Md.

24a. REC'D BY REGISTRAR DATE: 11/6/57

24b. REGISTRAR'S SIGNATURE: Julia A. Brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11950

CERTIFICATE OF DEATH

Reg. Dist. No. 11959 / 166

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL OAKLAND
c. LENGTH OF STAY IN 1b: 4 YEARS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RXO RURAL OAKLAND MD
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First GARRY — Middle LEE — Last RIDDER

4. DATE OF DEATH: Month NOV. — Day 22 — Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY-13-1869

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): GARRETT Co.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN RIDDER

14. MOTHER'S MAIDEN NAME: KATHRYN WILT.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: DAVID RIDDER OAKLAND. MD. RT.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia & Heart Disease
434.3
DUE TO (b): Heart Disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 21st, 1957, to Nov 22nd, 1957 that I last saw the deceased alive an _____, 19____, and that death accurred at 4:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J W Wenzel M.D. — ADDRESS (Street, city or town, state): Oakland Md English St — DATE SIGNED

PHYSICIAN'S NAME (Type): J OHN Wm WENZEL

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: NOV-24-1957

22c. NAME OF CEMETERY OR CREMATORY: RED HOUSE CEMETERY

22d. LOCATION (City, town, or county) (State): RED HOUSE. NEAR OAKLAND MD

23. FUNERAL DIRECTOR'S SIGNATURE: Emroy Bolden — ADDRESS: OAKLAND. MD.

24a. REC'D BY REGISTRAR DATE: 11/24/57

24b. REGISTRAR'S SIGNATURE: Julia A Howard LR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11951

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11960

Reg. Dist. No. 166

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b: 10¼ HOURS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 SWANTON
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): GARRETT COUNTY MEMORIAL HOSPITAL

3. NAME OF DECEASED (Type or print): First FREDA — Middle CREOLA — Last SWEITZER

4. DATE OF DEATH: Month NOVEMBER — Day 13, — Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 28, 1919

9. AGE (In years last birthday): 38 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Own Ho me

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ARTHUR RHODES

14. MOTHER'S MAIDEN NAME: ROSE BUCKALEW

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): UNKNOWN (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ----

17. INFORMANT: HOWARD SWEITZER, Address: SWANTON, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 331x Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 11 Hours
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. I. Baumgartner M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: NOVEMBER 13, 1957

EXAMINER'S NAME (Type): E. I. BAUMGARTNER, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/15/1957
22c. NAME OF CEMETERY OR CREMATORY: George Cemetery
22d. LOCATION (City, town, or county) (State): Near Swanton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. C. Leighton
ADDRESS: Oakland, Md.

24a. REC'D BY REGISTRAR DATE: 11/13/57
24b. REGISTRAR'S SIGNATURE: Julia A. Stewart R.A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11952

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11961

Reg. Dist. No. 166

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT. LAKE PARK
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: GARRETT.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo MT. LAKE PARK.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: RUBY — Middle: KATHRYN — Last: TURNEY
4. DATE OF DEATH: Month: NOV. — Day: 22 — Year: 1957
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. - 17 - 1901
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): CLEVELAND OHIO
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: FRANCIS VAN TYNE.
14. MOTHER'S MAIDEN NAME: WINIFRED WARNER.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: HARRY TURNEY — Address: MT. LAKE PARK, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 2 days
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☐ and find that death resulted from: Natural couses ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. J. Bannvartner M.D.
EXAMINER'S NAME (Type): E. J. BANNVARTNER
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: 11/25/57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: NOV.-25-1957
22c. NAME OF CEMETERY OR CREMATORY: OAKLAND CEMETERY
22d. LOCATION (City, town, or county): OAKLAND (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: Emroy Boldin ADDRESS: OAKLAND MD.
24a. REC'D BY REGISTRAR DATE: 11/25/57
24b. REGISTRAR'S SIGNATURE: Julia A Bowman LR

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55